Utah Digital Health Service Commission Meeting
Thursday May 1, 2014, 10:00 a.m. – 12:00 p.m.
Utah Department of Health, 288 North 1460 West, Rm 114, Salt Lake City, Utah

Minutes

Members Present: Deb LaMarche (Chair), Mark Dalley, Henry Gardner, Chet Loftis, Dennis Moser (via phone), Jan Root (Vice Chair), Nancy Staggers , Sarah Woolsey (via phone)
Members Absent: Scott Barlow, Craig Herzog, Marc Probst
Staff Members: Humaira Shah (UDOH)
Guests: D. Wain Allen (Kamas Health Centers), Brenda Bryant (UDOH), Courtney Dinkins (AUCH) (via phone), Gina Flanagan (Wayne County Community Health Center), Rich Lakin (UDOH), Preston Marx (Uintah Basin Healthcare), Sheila Walsh McDonald (UDOH), Josh Nelson , Wyatt Parker (HealthInsight), Ruben Rocha (Salt Lake Community College), Robert Rolfs (UDOH), Iona Thraen (UDOH), and Joe Wivoda (National Rural Health Resource Center)

Introduction and Welcome:

Deb LaMarche began the meeting with introductions. There is a motion to approve the March minutes with one change added. The motion is moved, seconded and passed.

Recap the Meaningful Use Discussion and Recommendation:

Deb summarized the last two commission meetings. She proposed that the commission work with Wu Xu and Jan Root on drafting a letter of recommendations to Dr. Patton so the commission has the opportunity to make recommendations that could be approved for July.

The State of HIT Adoption and Utilization in Rural U.S.

Joe Wivoda discussed the National Rural Health Resource Center; a nonprofit organization dedicated to sustaining and improving health care in rural communities. He also discussed the current levels of EMR adoption with U.S. hospitals in 2013. Urban hospitals on average are on stage 4, rural hospitals are at Stage 3 in the United States EMR Adoption Model (Meaningful Use Stage 1). The challenges are then discussed. What needs to be done is building capacity along with clinical data exchange, and also quality measures tackle workforce challenges and prepare for health reform. With building capacity there needs to be strategic thinking while reacting tactically. We need to learn to prioritize with multiple priorities in mind and make process improvement part of our culture and growth capacity from within. Clinical data exchange is an important strategy for improving health in our communities. We need to understand why exchange is important and how it can be accomplished, and that requires talking with patients and providers. Direct secure messaging will change the way we operate and you need to understand how it works and how you can implement it. Clinical quality measures will hopefully be done electronically this year. They will be increasingly important for meaningful use, Public reporting will be required. Process improvement will be critical and redesigning processes to be able to exchange messages and other things. Workforce challenges, you should grow from within, and you should also look out. In order to prepare for health reform, there needs to be a shift from volume to value. Value=quality/cost and HIT needs to be an enabler.

There was a question about quality measures. "I have already changed my quality goals twice in the last month based on the new data and some of the quality measures now are written in stone. I anticipate that will take months to get officially approved. How are we going to manage that? Specifically blood pressure goals and Beta blocker usage? If you are being graded on Beta blocker usage and suddenly the recommendation changes, that is probably not going to filter down for months and you'll have to fail to meet the quality goals."

Joe Wivoda answered that someone asked a similar question the other day, and wondered why we couldn't just use the reports that are built into our EHR and be done with it. He said you couldn't do that and it's going to require everyone to do their own custom reporting. We are going to have to have the capability to do that and there is a lot to the power of networking.

Henry Gardner asked in terms of telemedicine, how is this all fitting together. He answered that telemedicine has been very frustrating, the primary frustration has been reimbursement. It has held telemedicine back. Technology wise, a lot of people can do it but on the other hand we have been held back by reimbursement and process improvement. It is going to be a critical offering in rural facilities, particularly in health reform.

Rural Hospitals' IT Perspective

Preston Marx is the VP of information technology at Uintah Basin Healthcare. He gave some background on Uintah Basin Healthcare which services 3 counties; Daggett, Duchesne, and Uintah. He discussed the broad spectrum of services they offer to the community as well as the outreach clinics. There were some significant achievements in the past few years. Cerner implementation in 2012, HIMSS analytics stage 6 award 2014, Utah Telehealth network member with working on the Utah Arches project and bringing USDA HD videoconferencing equipment, and they also been working through meaningful use and are currently working on reaching Stage 2.

He discussed some of the challenges and opportunities. The first is the future of healthcare. We are all worried about healthcare reform and declining reimbursements and what that is going to mean to us, but in a rural setting we are typically insulated from the change. However, when the change comes it can be detrimental and devastating because we are running on such a thin margin so we are conscious about that. We look to Teleheath as being either a great challenge or a great opportunity for us. I believe it will make geographical boundaries obsolete so people can choose a provider from anywhere. The next item is that the complexity of health IT has grown immensely. It costs a lot to put in place and it costs even more to sustain it. We struggle with expertise, our depth is shallow, and we could use help from an outside entity to help with technical and clinical expertise.

Iona Thraen had a question in regards to struggling with technical expertise, and asked to be more specific about it. He said five years ago we were trying to connect 30 computers on a handful of network switches which weren't very smart in their ability to route traffic. Now, by purchasing an EMR, we have 600 computers and 60 switches that all have to interconnect and work at gigabit speeds. That has been a challenge; we don't have a network engineer on site which has been a big challenge from a technical aspect.

The discussion continued with things that were beneficial. One thing we have done that has been beneficial is I have recruited several RN's to IT. Another challenge we see in the connection between our rural sites and the tertiary facilities is when a patient is transferred, how do we get them back or monitor

them. We are doing a lot of education and teaching our referral partners about how we need to transfer this data electronically rather than send it with the patients. The last challenge is how do we bring out ambulatory clinic physicians on board. Their EMR adoption rate has been so much slower for us than in other areas, they seem to fight the systemization health care in a rural setting, and they are much more maverick in their approach to health care. Trying to bring them into the network has been a challenge for us. Our plan is to move forward with our mission which is to provide health and healing to every person every time. We approach healthcare in our community with an ACO mindset. We feel very at risk for all of our community members and want to provide the quality of care they deserve and need.

Sarah Woolsey asked what are the percent of offices that use EMR's? Preston Marx said our partners are in network with almost every physician in our town of Roosevelt. They are all on the same system, not only Cerner but our Cerner. Our issue now is to bring in all the physicians in Vernal and some of the outlying areas to communicate and talk with us. We are probably 95% EMR within Roosevelt and 40-50% within 3 counties.

The real challenges we all have in rural areas are resources and expertise.

Deb said one of the things that struck me that Preston said was going from 30 computers to 600+ devices. All of the rural hospitals have hundreds of devices which is a huge expansion from not too long ago so even just the size of the internal network is really high.

Community Health Centers' Perspective

Gina Flanagan began her discussion by talking about the location of the center and what they do. About 20% of their total operation is grant funded to offer services to the uninsured and low income. Both Garfield and Wayne counties are the poorest counties in the state of Utah. About 40% of their population is below 200% poverty and uninsured. Health information technology started with medical services in 2009. Our part of the national health choice network is from Florida, they have quite a few centers nationwide and are helping implement EHR's. We are totally electronic now in pharmacy, dental, and medical. We have gotten meaningful use the last 3 years and it is great but very costly. Furthermore, we have an IT person but most of our sister clinics could not afford it. We are a Utah telehelath network partner and they have helped us in many ways, one being security. We want to be the best but it is hard with limited resources. One thing I worry about because of our isolation in a natural disaster. We have done contingency planning to try and plan for that like keeping CCD's on site but those are not user friendly. I am concerned about when the Meaningful Use funds will go away, they are supporting our program and if those go away we won't be able to afford it and the costs associated with it.

Rural Physician's Perspective

Dr. Wain Allen has been doing EMR's for 15 years and has been paperless for about 7 years. We were excited about Meaningful Use but since we are rural health clinics, and the only privately owned rural health clinic around, we don't qualify so we did not do meaningful use stage 2. In our clinics, any patient that asks for getting their entire record put on a stick drive and then it is the patient's responsibility. They bring it in each time and we update it. Other providers will not put it in their system but will plug in the stick drive and view the patient's records.

Summarize the Discussion:

Dennis Moser asked Gina what EHR vendors the other community health centers use. Gina said there are five other centers and we are a small network of Utah health choice network as well.

There was a question about if there had been any kind of systematic review of the various rural provider communities in terms of the EMR model, and what the differences were in regards to the list of functionalities.

Jan said it is costly to upkeep the EMR's as well as the limited resources available and there is a deeper need for expertise. If there is a way to get these to rural in a meaningful way then it needs to be explored.

Joe mentioned a part he left out of his discussion. The HIT workforce program that is offered to the community college is 100% online; you can download the whole thing.

Deb said, In reference to the EMRAM model, are there grant dollars that could have resources to help? If there is way to maybe have some resources to come to these facilities and conduct an assessment. I realize all the commission can do is make recommendations, are there ways that we can actually make recommendations that can help address some of these issues? Some of them are so big rural and urban but is there anything we can do?

Dr. Allen said he would vote for simplification and removal of layers instead of adding more. Someone suggested starting with little pieces to help, and if that's successful the providers might say this works for this little smart health plan and then work up with baby steps.

Deb said that Gina mentioned talking about weather, power outages, and disasters. Part of what needs to happen is that the state needs to contribute more to developing redundant paths so that parts of rural Utah aren't going to be isolated. There should be multiple ways they can remain connected.

Discussion of the Digital Health Service Commission Act's Sunset Review by the Legislature in Late 2014

Sheila Walsh McDonald said the DHSC is due to sunset review by July 1, 2015. This commission and the value of the commission will be reviewed in this upcoming interim session by the Health and Human Services interim committee. It is tentatively scheduled for July of 2014 with representative Menlove. We will run legislation and if there is a decision not to sunset the DHSC during the 2015 session, we need to identify sponsors in the house and the senate and review the current statute to see if there are recommendations to update. The last time this statute was visited was in 2008 and was with a lot of the work we were doing with rural health care. In talking with Wu there have been some names, senator Vickers and representative Barlow as potential sponsors in our house and senate. It could be as simple as a request for reauthorization.

Other Business

Nancy Staggers mentioned that the Utah chapter of HIM is offering a day long spring conference, free to this body, and we would like to be able to forward the agenda electronically. Its $125 for an all day

session for those not on the commission and we have former senator Bell speaking about meaningful use and what it means to Utah with a panel of HIT adoption folks.

Deb said in the next meeting there needs to be an election for a chair and vice chair. Wu may ask for nominations via email.

Meeting adjourned.